Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHEOR J KIM, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2201-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual disputed the compensability of the entire claim on 6/30/10. Until final adjudication has taken place Texas Mutual maintain its denial for the claimant-requested designated doctor examination of 12/22/10."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. HWY 290, AUSTIN, TEXAS 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2010	99456-RE-W7	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041 provides general provisions for DD Examinations and carrier responsibilities for payment of such services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 26, 2011
   - CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSED AS BILLED.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

   Explanation of benefits dated February 18, 2011
   - CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSED AS BILLED.
   - 907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY.

Issues

1. Has the requestor's billing used correct modifiers for the service rendered?
2. Does the claim have compensability issues?
3. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds that the Division ordered and the DD billed the amount of $500.00 for CPT code 99456-RE-W7 to determine whether the injury was a Direct Result of the work related incident (DIR). Respondent denied services based on "CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING" and "732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFIER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSED AS BILLED." The original billing shows CPT code 99456-W5-W7 and reconsideration "corrected" billing modifiers show CPT code 99456-RE-W7, which is the correct CPT and modifier combination to describe services, therefore this denial reason is not sustained.
2. Respondent also denied services based on "CAC-B22 – THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS." and "907 – ONLY TREATMENT RENDERED FOR THE COMPENSABLE INJURY IS REIMBURSABLE. NOT ALL CONDITIONS INDICATED ARE RELATED TO THE COMPENSABLE INJURY." There is a PLN-11 on file dated June 10, 2010 which states:

   > "This claim is denied in it entirety. The employee did not sustain an accident or injury in the course and scope of her employment. Based on the carrier's investigation there was no witness to the reported injury. Employee's activities inconsistent with an injury. The reported injury was not reported to the employer until after she was denied unemployment benefits."

   The Designated Doctor specifically was ordered by the Division to address this situation and render an opinion on whether the injury was a direct result of the claimed injury. The doctor's narrative states:

   > "It is my opinion that a Lumbar sprain/strain, Left Shoulder sprain/strain resulted from the claimed 06-06-2010 incident."

   As the purpose of the Division ordered examination was to address these issues, the denial for any relatedness issues is not sustainable.

3. Texas Labor Code §408.0041 states in part (a)(4):

(a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

(4) whether the injured employee's disability is a direct result of the work-related injury;

Texas Labor Code §408.0041 states in (h)(1):

(h) The insurance carrier shall pay for:

(1) an examination required under Subsection (a) or (f).

28 Texas Administrative Code §134.204 states in part (i)(1)(D):

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W7;"

28 Texas Administrative Code §134.204 states in part (k):

(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

The Maximum Allowable Reimbursement (MAR) for the Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is $500.00 and this is the recommended reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 28, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.